(TYPE OR PRINT)

14-0011 (11/06)

FORM 100C

BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

Claimant_____

VS. Employer_____

Street_____

City_____State_____Zip_____

Insurance Carrier_____

Street_____

City_____State_____Zip_____

File Number _____

ORIGINAL NOTICE, PETITION, AND ANSWER CONCERNING APPLICATION FOR ALTERNATE MEDICAL CARE (IOWA CODE SECTION 85.27) (Rule 876 IAC 4.48)

Injury Date_____

Body Part(s) Injured _____

ORIGINAL NOTICE

To the Above-Named Employer:

You are notified that an action has been commenced before the Iowa Workers' Compensation Commissioner seeking relief as set forth in the petition below. **DUE TO THE TIME CONSTRAINTS, IT IS NOT NECESSARY TO FILE AN ANSWER.** If no answer is filed, a response will be required at a hearing. If it is disputed that the employer is liable on this claim, this case will be dismissed without prejudice. **NOTE**: You should promptly advise your workers' compensation insurance carrier and attorney that you have received this notice.

PETITION (To Be Completed By Claimant)

In support of this claim for alternate medical care, claimant states:

1. Claimant sustained injury arising out of and in the course of employment with the employer on (Date)_____
2. The injury occurred at (City)_____, (County)_____, and (State)_____.
3. The injury has caused need for medical treatment.
4. The treatment offered by employer is not reasonably suited to treat the injury without undue inconvenience to claimant.
5. Claimant is dissatisfied with the care provided and has communicated that dissatisfaction to employer. Reason for dissatisfaction and relief sought:
6. **A hearing is requested**
   - ☐ by telephone conference call; or.
   - ☐ in person

   to be held in Des Moines, Iowa (If neither party requests an in-person hearing, a telephone hearing will be scheduled.)
7. Employer does not dispute liability on this claim.
8. The provisions of Rule 876 IAC 4.48 are invoked.

(If Represented by Attorney)

Attorney_____

Street _____

City_____**State**_____**Zip**_____

_____

Attorney Signature

Phone (Include Area Code)_____

_____

(Claimant's Signature)

Claimant's Phone No. ( ) _____

(include area code)

Date signed:_____

_____

Email Address of Attorney

Fax (Include Area Code _____

Date Signed: _____

THE INFORMATION PROVIDED WILL BE OPEN FOR PUBLIC INSPECTION UNDER IOWA CODE §22.11

_____vs._____ File No. _____
Claimant Employer

PROOF OF SERVICE

On the _____ day of _____, _____, I mailed a copy of the foregoing original notice and petition by certified mail, return receipt requested, to the employer's last known address which is:_____

_____

I CERTIFY under penalty of perjury and pursuant to the laws of the State of Iowa that the preceding is true and correct.

Date_____ Signature_____

ANSWER (Employer/Insurance Carrier must answer on this form)

1. ***A hearing is requested.***
   by telephone conference call; or
   in person
   to be held in Des Moines, Iowa, (If neither party requests an in-person hearing, a telephone hearing will be scheduled.)
2. (Check if applicable) Employer denies paragraph 7 of the Petition and disputes liability of this claim.

Employer_____

Street_____

City_____State_____Zip___

Phone (Include Area Code)_____

Insurer_____

Street_____

City_____State_____Zip____

Phone (Include Area Code)_____

_____
Signature of Person Answering

Name:_____
Title:_____
Date signed: _____

(If Represented by Attorney)

Attorney_____

Street_____

City_____State_____Zip___

Phone (Include Area Code)_____

Date Signed: _____

INSTRUCTIONS - BOTH PARTIES MUST USE THIS FORM

To Claimant:

1. Alternate medical care is the only issue that can be considered under this procedure.
2. Complete lines 1, 2, 5, and 6 of the petition. Attach the claimant's confidential information sheet.
3. Deliver a completed copy of this form to the employer by certified mail, return receipt requested or by personal service as in civil actions (rule 876 IAC 4.7) and mail a copy to the employer's attorney of record for this file if known (rule 876 IAC 4.13).
4. Complete the proof of service portion on the original of this form and deliver this entire form with the physician's report to the Division of Workers' Compensation at 1000 East Grand Avenue, Des Moines, Iowa 50319-0209.

To Employer/Insurance Carrier:

1. If you file an answer, serve a copy to the claimant or claimant's attorney pursuant to rule 876 IAC 4.13.
2. Type or print the name and title of the person answering below the signature line.

Generally:

1. This procedure is not available if employer disputes liability on the claim generally. If liability is disputed, this case will be dismissed without prejudice. Disputed cases should be commenced under rule 876 IAC 4.1

IOWA WORKFORCE DEVELOPMENT

14-0011 (back) (11-06) (revised to fillable 2-09)
Form 100C